Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TROPHY CLUB MEDICAL CENTER
2850 E HIGHWAY 114
TROPHY CLUB TX 76262-5302

Respondent Name
Old Republic Insurance Co.

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-11-2965-01

MFDR Date Received
May 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim submitted November 10, 2010 Lack of acknowledgement from carrier."

Amount in Dispute: $958.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response

Response Required by: Old Republic Insurance Co.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2010	Outpatient Hospital Services	$958.36	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out procedures regarding reconsideration of medical bills.
3. 28 Texas Administrative Code §133.305 sets out general provisions related to medical dispute resolution.

Issues

1. Does the request meet the requirements for medical fee dispute resolution?
2. Was the request for medical fee dispute resolution filed in the form and manner prescribed by the Division?

Findings

1. Per 28 Texas Administrative Code §133.250(h),effective May 2, 2006, 31 Texas Register 3544, "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with §133.305." 28 Texas Administrative Code §133.305(a)(4)(A), effective May 25, 2008, 33 Texas Register 3954, defines a medical fee dispute as "a health care provider . . . dispute of an insurance carrier . . . reduction or denial of a medical bill." Review of the submitted information finds no documentation to support that the insurance carrier took final action on the disputed medical bill after reconsideration. No documentation was submitted to support that the insurance carrier reduced or denied the disputed services. The Division concludes that the requestor has failed to establish that the request for medical fee dispute resolution meets the requirements of §133.250(h) and §133.305(a)(4)(A).

2. 28 Texas Administrative Code §133.307(c)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include a copy of the EOB detailing the carrier response to the provider's initial bill./ Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).

Conclusion:
For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 27, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.